Humanizing Health Care Services

The Practice of Medicine as a Moral Enterprise*

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UNTIL recent years, the term "medical ethics" generally referred to matters rather formal —such things as fee scales, liability when administering emergency treatment, protection against criminal charges, and so on. This focus tended to obscure the fact that the physician is faced daily with the responsibility for making moral decisions about health care—decisions requiring a great deal of personal investment—with virtually no help or support from the clinical structure within which he works, other than certain formal and/or legal safeguards put forth as "policy." This paradoxical situation was maintained at the same time that it was becoming increasingly clear that medicine must face the necessity of concretely demonstrating its willingness to assume a greater ethical responsibility for the good of those whom it serves.

The tenor of clinical practice has changed in the past several years, producing a heightened awareness of the moral dilemma of the physician. This paper will attempt to outline three aspects of medicine in which this dilemma is present and then suggest several steps which might be taken to meet emerging moral responsibilities.

The largely procedural and protective character of formal medical ethics is in striking contrast to the broad humanistic values upon which medicine itself is based. Through scientific and technological refinement, the framework of medicine has become increasingly *abstract* as it has become more *exact.* This is obvious when one looks at increasing specialization, greater concentration on laboratory skills, and more students heading into research. It has become much more difficult for the practicing physician to remain in touch with the *human* basis of his profession: his pledge to "preserve life and relieve the suffering" of his fellow man.

MEDICAL EDUCATION

Part of the problem has been built into the process of medical education itself. The focus of medical training is on reduction and control. There is a conscious attempt to weed out personal and subjective factors to prevent the contamination of research or the clouding of diagnostic ability. An effort is made to depersonalize the interpersonal exchange in the clinical setting, whether or not the focus is on physiological or psychological processes. Medical students are conditioned to suppress anxiety—especially their anxiety connected with close interpersonal contact.[1] But suppression does not mean the elimination of anxiety, or of its causes. And too often these factors have not been suitably recognized or dealt with.

This is not to suggest that efforts at objectification are wrong. They lead the student into a role in which he is able to confront highly emotional situations without experiencing debilitating stress, in which he can function efficiently under crisis conditions, and in which he can evaluate data and make predictions with a high degree of accuracy. This form of training might even include an "escape valve" for the future physician's own emotional and interpersonal inclinations by enabling him to anthropomorphize the functions and materials with which he works. Like the cowboy whose best friend is his horse, the physician's allies are the scalpel, the microscope, and the antibiotic, that join him in the battle against the "forces of evil."

The major problem with these training efforts is that they do not help the student learn to deal

* The term "moral" in this context refers to a range of value, from best to worst. This generic usage recognizes that the contents of morality may vary from one situation to another. Medical ethics, then, is seen as a form of *social inquiry,* the purpose being to reflect upon experience and to systematically clarify the values which shape patterns of action.

with the *patient* as a partner in the endeavor to restore health. In fact, many students are directly or indirectly encouraged to view the patient as a potential source of interference in the treatment process!

THE TREATMENT OF PATIENTS

The second concern follows directly from the first. A person treated as an object—even for his own eventual good—is somehow dehumanized. This medical dilemma might be understood as a conflict between *function* and *being*. The term "function" refers to the quality of fulfilling a need, or to that which is valued for a particular purpose. The major functional question is how something will be utilized. Medicine is mainly concerned with functions, and properly so. There are myriad questions about the correct utilization of materials, such as antibiotics; of treatment procedures, such as dialysis; and of policies, such as family permission for research techniques.

In the intensity of the functional focus, however, it is easy to overlook or minimize the other quality which is inherent in medicine's concern for human life and health. This is the dimension of "being." By talking of "being," we refer to that which is the bearer of dignity and responsibility in itself. In man, it is the uniquely human, regardless of how that quality is conceptualized in religious or philosophical terms. Kant referred to man as "an end in himself." The major question here is how being will be met, or encountered. The encounter with being has become a prime problem for contemporary medicine, as well as for other major social institutions such as law and education.

It simply is not possible to understand or interact fully with another person in strictly functional terms. The person's "being" will always be present and influential. A social philosopher, Floyd Matson, has written: "If we wish to know the meaning of behavior, we must know the *meanings of the behavior;* to remain outside his frame of reference is simply to remain in the dark."[2] Similarly, a physician recently remarked that, in the final analysis, the patient is probably the best "expert" on his own problem or disease. Thus, history-taking interviews play perhaps the most crucial role in diagnosis.

This matter of *meaning* seems central to the practice of medicine. In recent years, for example, more and more of the psychiatric profession has come to share the belief that, even in the case of the most bizarre psychosis, the patient means, or intends, something by his behavior, something which is crucial to understanding him as a person and to treating him effectively. Similarly, other practitioners are confronted often with the problem of meaning in the diagnosis and treatment of illness. This is perhaps most apparent in psychosomatics, but is also true of other realms of medicine; for example, in the treatment of a terminally ill patient whose intention to live or to die seems somehow to influence the course of his pathology.

THE MEANING OF HEALTH

A third major factor to consider in confronting the moral dilemma of medicine is the problem of the articulation of "health" as a basic or ultimate value. Health is a value, one which must be constantly re-examined and re-interpreted in the changing context of cultural history. There iis no single definition of health. In the late 1950s, psychologist Marie Jahoda surveyed mental health professionals and listed a dozen different *classes* of health definitions.[3] Today the list would certainly be much longer. We are in the midst of a social revolution, and this revolution includes a radical change in our understanding of the meaning of health—for both individual and community—and of health maintenance by the medical profession.

The philosopher and theologian Paul Tillich has pointed out that since life itself is "a multidimensional unity," our understanding of health, of disease, and of the healing process must also be multi-dimensional.[4] For example, in the physical dimension of life, health can be seen as the adequate functioning of organs and organ systems, and disease as their non-function or impaired function. In the psychological realm, health is the power of self-actualization without the loss of a stable sense of identity. Disease in this dimension can be seen as either a withdrawal from life into a limited form of experiencing, or a diffusing of identity and a resultant loss of centered stability. The implication of these differentiations for the practice of medicine is that in the interplay of dimensions, healing can never be seen as total. Healing in one dimension may very well provoke disease in another dimension. Or one

may have to settle for partial healing in all dimensions. An obvious example of this is the phenomenon of side effects in various forms of chemotherapy; another is the decision of the psychiatrist to allow a patient to use certain psychic "crutches," or defense mechanisms, as an aid to improvement in social interaction.

This relativity in the healing of various dimensions of life means that the several professions involved in healing must cooperate, or that one particular kind of healer must perform various kinds of functions. These facts have been recognized in the growing awareness of the "priest-like" role of the physician as well as in the increasing cooperation of physicians with other medical and paramedical personnel working for the total good of the patient. The concept of a coordinated health care team is emerging as one of the major challenges to medicine in this decade.

It is worth noting the implications of what has been said for community health services. When one considers the social-historical dimension of life, a decisive question is raised: to what degree is personal health possible in a *society* which is not perfectly healthy? The answer is that healing is obviously hindered by the sicknesses of society, and so the medical profession is required to turn some of its attention to altering the milieu within which sickness originates. Social context and general conditions of life have much to do with making persons become patients. When this is recognized, then a moral demand is placed upon medicine to help humanize the society—and the place to begin this is certainly within the profession itself!

However, a word of caution must also be sounded. It is an illusion to believe that a total health utopia can be achieved through the creation of a perfectly "sane society." Any of the ways which man will ever devise for advancing social good will be open to demonic distortion through unwise action. We must always choose anew between the means available to achieve certain ends. This capacity to choose between certain avenues of action is the essence of the moral dilemma. From this standpoint, it is obvious that medical practice, and particularly the relationship between physician and patient, is a moral enterprise *sine qua non.*

SEARCHING FOR SOLUTIONS

Up to this point, much has been said about problems and very little about solutions. This is partly intentional, since understanding the exact nature of a problem often leads one a long ways toward a solution. In this instance, however, there is no single solution to the moral problematic inherent in medicine. Answers will emerge from the collective human wisdom of practitioners and critics who are willing to assume the burden of examining the moral aspects of medicine. Here we will simply suggest some concepts which might serve to guide such an examination.

First of all, in terms of its training processes, medicine can self-consciously re-examine its understanding of what a "profession" (any profession) really is, in order to determine whether it is providing a genuinely comprehensive professional education for its students. To be a professional implies four basic things: 1) that one has mastered a certain body of knowledge and is willing to be held accountable for it; 2) that one can apply this knowledge in effective practice; 3) that one is a participating member of a community of peers who can and do provide feedback on experience and can exercise the functions of criticism and evaluation, as well as lending positive support for actions undertaken; and 4) that one is involved in some kind of commitment to the good, however that may be defined, so that one feels the demand of a moral imperative and is able to respond to it in some responsible way. Modern medicine has given most weight to the first two of these criteria. The present situation may well call for a realignment of priorities.

Secondly, medicine can take steps to re-humanize the patient. This requires the recognition that in confronting the patient, the physician "inherits a *situation*" which goes far beyond the confines of the hospital bed, the operating room, or the clinic. One way to foster this recognition is to admit that data about a situation or problem is gathered in two ways. One way is the empirical, objective method which defines, measures, and verifies. This is a crucial tool for the practice of medicine. But just as important, though more often neglected, is the method of achieving *understanding through participation.* This method seeks to discover a shared reality.

From his work with schizophrenics, Harry Stack Sullivan developed what he termed the "one-genus hypothesis." It asserted that we are all much more like the sickest individual than we are different from him.[5] And so, for example, in its research, medicine can make more use of participant-observation and structure some of its projects along the lines of action-research models. Likewise, in treatment the physician can offer the patient the opportunity to genuinely *share* in the process of making critical decisions, so that "informed consent" becomes a reality. Medicine can work to develop creative "consensus models" for decision-making. Involved in these might be not only the doctor and his patient, but also representatives of paramedical professions and perhaps even members of the community at large, when far reaching policies or critical matters of life and death are involved.

Finally, medicine must re-define what it means to promote health and to deliver health care. Our view of health must derive from an up-to-date concept of the nature of the person and his interrelation with his community. Further, it must reflect an ethical sensitivity to serious questions about the quality of human life, rooted in a realistic appraisal of the impact of modern technology on living and dying. Our use of the term "health" reflects nothing less than our basic understanding of man's nature, his goals and aspirations. The past several decades have taught us that the sixteenth century Newtonian physics model of the universe is only *one* way of interpreting reality. Now it is time for medicine, following the lead of other natural and social sciences, to reflect the influence of open-system models of thought. Specifically, medicine must increase its capacity to see "health" as a phenomenon of both function and meaning. That is, all human functions—or malfunctions—must be interpreted at the same time in relation to their meaning to the patient and to the community of which he is a part. We must build this vision into our fundamental understanding of the clinical situation.

Many medical schools have been forced to acquire a social conscience in the past few years. Gradually they are coming to view themselves, along with their teaching hospitals and auxiliary facilities, as community resources. There is a growing cooperation between health care facilities and other community institutions. Yet much more needs to be done, particularly at the level of interpersonal contact between professional and patient. Some medical schools are now emphasizing the interaction of the clinician with patients, training students to function more effectively as interviewers, sympathetic listeners, and even counselors. Others are extending the influence of the medical and paramedical support personnel so that there is a broader base of input into decisions regarding diagnosis, treatment, and clinical policy. Some schools are even taking steps to structure training in such a way that students experience the role of patient in order to gain insight into additional data that the patient can provide. Such training innovations, along with new interpretations of preventive care and health maintenance, should certainly be extended.

An awareness of the moral dimension of clinical practice is increasingly essential if medicine is to meet the challenges of the future—some of which are as yet unknown. When we deliver health care which makes it possible for every child, black or red or white, urban or rural, to reach school age physiologically capable of participating in the educational process to the fullest extent of his innate potential, then medicine is meeting its moral responsibilities. When we help society to provide a *purpose* for maintaining the vital processes of an aging person as well as a *method* for doing so, then medicine is meeting its moral responsibilities. When we help make it possible for man to maintain an optimal population on this planet without waging periodic self-destructive wars over space, resources, and the minds of other men, then medicine is meeting its moral responsibilities. Obviously medicine cannot—and should not—do all these things alone. However, they are legitimate concerns of medical practice, and as such they must not be neglected or ignored. To do so would plainly be immoral.

SUMMARY

The moral aspects of medical practice are examined, with particular focus upon factors influencing the clinician's view of his own role, of his social interaction with the patient, and of his understanding of the concept of "health."

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Some clarification must be made here, however, for the program was not the sole input into the educational system. The Office of Student Affairs, with the substantial help of the students, recruited an assistant dean whose primary concern was the enabling of future programs and minority affairs generally. In addition, the slow but real growth of black students in the school had produced a critical mass—a sociological unit—which was large enough to begin to play a visual role in the student affairs of the school. It was a unit on which black students could rely, to which they could turn for support both emotional and academic. These indirect products of Macy's input had to have some effect on the results of the program—certainly enough to prohibit any attempt at precise measurement of the impact of the program alone.

A second clarification ought to be made as to the estimate of success. Given our stated goal of recruiting from the "average" student rather than the "high achiever" and given the expectation that these non-competitive students would have a reduced chance for academic survival, we have succeeded. Of the nearly 30 odd students admitted to the school who also participated in the last three programs, only one is no longer enrolled. Some have had to repeat all or part of a year and many are having or have had difficulty handling the academic demands the system imposes but they are still with us and will most likely graduate. There is no question that in terms of preparing students for the rigors of medical education they are far better off with the experience than without it.

Our mistakes lie largely in the realm of downgrading the offerings of experience. One major oversight was our failure to respond to the statement made by the students (above) which identified "inadequate study skills" as one major problem. Some of the students' difficulties can be mitigated by including into the program a curriculum designed to supplement, remediate or reinforce efficient study skills.

In summary, we have succeeded in a modest way of increasing the enrollment of minority students in the school. We have been successful in holding the attrition rate (as measured by enrollment rather than advancement) at a reasonable level. We have not been successful in alleviating the tremendous anxiety and occasional despair of students who must daily struggle for academic survival. We have not appreciably lessened the racial tensions within the institution engendered, on the one hand by this constant anxiety and on the other by a lack of sensitivity to its origins and implications.

The most successful aspect of our efforts has been the blending of students and the faculty in the delivery of the program. It represents an application of the combining of imagination with experience, of knowledge at many levels to meet Whitehead's dictum regarding the task of the university.

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Some suggestions are made for helping the medical student and the practicing physician become more sensitive to the human aspects of clinical practice. The medical community is challenged to see itself as a moral as well as scientific contributor to the society.

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